Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
STEVE SACKS, MD

Respondent Name
CITY OF HOUSTON

MFDR Tracking Number
M4-14-1843-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
FEBRUARY 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was billed per Medical Fee Guideline conversion factors as established in 28 Texas Administrative Code 134.203."

Amount in Dispute: $116.17

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation no additional recommendation is being at this time. This bill was correctly paid based on Fee Schedule in a previous bill submission."

Response Submitted by: Injury Management Organization

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2013	CPT Code 99203 New Patient Office Visit	$16.83	$0.00
	CPT Code 95886 (X3) Needle EMG	$39.60	$0.00
	CPT Code 95911 Nerve Conduction Studies (9-10)	$34.74	$0.00
	HCPCS Code A4556 Electrodes	$25.00	$0.00
TOTAL		$116.17	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers compensation state fee schedule adjustment.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 97, W3- The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.
   - 222-Charge exceeds fee schedule allowance.
   - 601-Per the fee schedule this service or supply is considered bundled.

Issues

1. Is the requestor entitled to additional reimbursement for CPT codes 99203, 95886, and 95911?
2. Is the allowance for HCPCS code A4556 included in the allowance of another service rendered on the disputed date of service?

Findings

1. The issue in dispute is whether the requestor is due additional reimbursement for CPT codes 99203, 95886, and 95911?

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2013 DWC conversion factor for this service is 55.3.

   The Medicare Conversion Factor is 34.023

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77042, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Houston, Texas".

   Using the above formula, the Division finds the following:

Code	Medicare Participating Amount	Maximum Allowable	Carrier Paid	Due
99203	$108.37	$176.14	$176.14	$0.00
95886	$84.97 (X3)	$414.32	$414.33	$0.00
95911	$223.49	$363.25	$363.25	$0.00

2. HCPCS Code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."

   28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Per Medicare policy, if HCPCS codes A4556 is incidental to the physician service, it is not separately payable.

A review of the submitted documentation does not support a separate service. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due for the specified services. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/04/2014
Signature	Medical Fee Dispute Resolution Officer	

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.